International Journal of Education and Science Research Review
E-ISSN 2348-6457
Volume-2, Issue-2 April- 2015 P-ISSN 2349-1817
www.ijesrr.org Email- editor@ijesrr.org

Effectiveness of CBT with Schizophrenic Patients in Rehabilitation a Therapist's Experience

GARIMA KAPOOR
Research Scholar
Department of Psychology
Mewar University Chittorgarh Rajasthan

Dr. Rakesh Kumar
Visiting Professor & Research Supervisor
Department of Psychology
Mewar University Chittorgarh Rajasthan

ABSTRACT:
The study was conducted on 25 patients with schizophrenia, all randomly selected from rehabilitation centres, with age ranges between 18-50 years. Researches on CBT with schizophrenic patients showed positive results in past. The current research is taking it forward studying the effectiveness of CBT intervention with schizophrenic patients in rehabilitation setting including the therapist's experience while using those CBT interventions with patients. Pre and post interventions PANSS scores showed considerable improvements in patients' symptoms and in their recovery suggesting usefulness of CBT with patients having schizophrenia. With these results the therapist's experiences talks about what worked and what difficulties were faced in the therapeutic process.

KEY WORDS: Schizophrenia, Cognitive Behaviour Therapy, Rehabilitation

INTRODUCTION:

Schizophrenia is the most severe and crippling of the psychiatric disorders. It typically strikes as adulthood is approaching and is likely to be disabling for a lifetime. Schizophrenia occurs in all countries, cultures, and socioeconomic classes; affects both sexes equally with typical age of onset appears to be younger in males (about 21 years of age) than females (about 27 years) (Oxford Textbook of Psychopathology, 1999). Nature, 1988 a clinical syndrome with a profound influence on public health, Schizophrenia has been called "arguably the worst disease affecting mankind, even AIDS not expected" (Neeraj Ahuja, 2011).A number of clinicians of the nineteenth and early twentieth century – Philippe Pinel, Emil Kraepelin, and Eugen Bleuler- carefully studied Schizophrenia and influenced the way modern medicine think about and diagnose Schizophrenia (Lieberman and Murray 2001). In 1801 Pine emphasized 'the rapid uninterrupted alteration of isolated ideas and of trifling and unsuitable emotions, disordered movements, and continued and extravagant acts'. Later on in nineteenth century John Haslam a writer presented clearer picture of schizophrenia. He noted that patients neglect those things that had previously held their attention, their affect becomes blunted and if they rad they cannot remember what they read. With this their apathy increases, they neglect their attire and personal cleanliness. In whole in the interval between puberty and manhood 'there is this hopeless and degrading change' (Lieberman and Murray 2001). In 1896 Emil Kraeplin differentiated the major psychiatric illnesses into two clinical types – Dementia Praecox and Manic Depressive illness. Under Dementia Praecox he included paranoia, catatonia and hebephrenia with emphasis in diagnosis of it was on early onset and poor outcome. The characteristic features of Dementia Praecox were delusions, hallucinations, disturbance of affect and motor disturbances (Neera Ahuja, 2011). In 1911 EugenBleuler introduced the term 'Schizophrenia 'with the emphasis on splitting (schizo) of the mind (phrenia). He described schizophrenia as a group of disorders characterized by hallucinations, delusions, and thought disorganization (accessory or secondary symptoms of schizophrenia)in individuals who were young and otherwise healthy. He also introduced the concept of four primary symptoms of schizophrenia (fundamental symptoms): Ambivalence, Autism, Affect disturbances and Association disturbances (Lieberman and Murray 2001).In the middle of the twentieth century Kurt Schneider gave importance to specific symptoms which he called first rank symptoms which he considered characteristic and diagnostic but not basic to the disorder (Lieberman and

Murray 2001).The distinction between positive and negative symptoms of schizophrenia was first discussed in detail by Hugh lings- Jackson (1931),a prominent neurologist. In the early 1980s Anderson a leader in development of modern nosology and her colleagues developed two scales: the Scale for the Assessment of Negative Symptoms and the Scale for the Assessment of Positive Symptoms (Oxford Textbook of Psychopathology, 1999).Based on which the positive symptoms of schizophrenia are hallucinations, delusions, positive thought disorder, bizarre or disorganized behaviour, and catatonic motor behaviour. The negative symptoms of schizophrenia include affective blunting (impoverishment of emotional expression, reactivity, and feeling), alogia (poverty of thoughts/ speech), anhedonia (inability to experience pleasure), associability (lack of desire to form relationships) and a volition (lack of motivation).There are sub types of schizophrenia: Paranoid, Hebephrenic (also called disorganized), Catatonic, Undifferentiated, Simple and Residual schizophrenia (WHO, 1992). Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually with hallucinations, particularly of the auditory type, and perpetual disturbance. Catatonic schizophrenia is dominated by prominent psychomotor disturbance that may alternate between extremes such as hyperkinesias and stupor, or automatic obedience and negativism (WHO, 1992). Hebephrenic schizophrenia is a form of schizophrenia which is dominated by prominent affective changes, fleeting and fragmentary delusions and hallucinations, irresponsible and unpredictable behaviour (WHO, 1992). Undifferentiated schizophrenia is psychotic conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the subtypes, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics (WHO, 1992). Residual schizophrenia is a chronic stage in the development of a schizophrenia illness in which there has been clear progression from an early stage to the later stage characterized by long-term, though not necessarily irreversible, "negative" symptoms, e.g., psychomotor slowing (motor retardation); under-activity; blunting of affect; passivity and lack of initiative (avolition); poverty of quality or content of speech (alogia); poor nonverbal communication by facial expression, eye contact, voice modulation and posture; poor self-care and social performance (WHO, 1992). In Simple schizophrenia there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance (WHO, 1992). The characteristic negative features of residual schizophrenia (e.g. blunting of affect and loss of volition) develop without being preceded by any overt psychotic symptoms (WHO, 1992).Other subtypes are: Pseudo neurotic Schizophrenia with three classical features – pan anxiety (diffuse, free floating anxiety which hardly ever subsides), pan- neurosis (almost all neurotic symptoms may be present) and pan sexuality (constant preoccupation with sexual problems) Schizophrenic form Schizophrenia – the only difference is that the duration is less than 6 months and prognosis is usually better. Type l and type ll Schizophrenia- type l syndrome is characterized by positive symptoms while type ll is predominantly characterized by negative symptoms (NeerajAhuja, 2011). Some important contributing factors appear to be genetics, early environment, neurobiology, psychological and social processes; some recreational and prescription drugs appear to cause or worsen symptoms. Current researches are focused on the role of neurobiology, although no single isolated organic cause has been found. The many possible combinations of symptoms have triggered debate about whether the diagnosis represents a single disorder or a number of discrete syndromes. Management or treatment of schizophrenia includes pharmacological treatment (medication), psychosocial treatment and rehabilitation. Psychosocial treatment is an important component of comprehensive management of schizophrenia which includes Psycho education, group psychotherapy, family therapy, individual psychotherapy, and psychosocial rehabilitation. Cognitive Behaviour Therapy CBT plays a major role in providing psychosocial treatment. Several centres (and guidelines) recommend the use of cognitive behaviour therapy in the treatment of schizophrenia [e.g. NICE (National Institute of Clinical Excellence, UK) Guidelines of Schizophrenia 2009] (NeerajAhuja, 2011).Cognitive Behavioural Therapy assumes that changing maladaptive thinking leads to change in affect and behaviour, but recent variants emphasize changes in one's relationship to maladaptive thinking rather than changes in thinking itself. Therapists make use of CBT techniques to help individuals challenge their patterns and beliefs and replace "errors in thinking which could be over generalizing, magnifying negatives, minimizing positives and

catastrophizing with more rational and effective thoughts, thus resulting in decreasing emotional distress and self-defeating behaviour(Wikipedia, The Free Encyclopaedia, last updated : 25 march, 2015)Some researchers have been done on the effectiveness of CBT with patients having schizophrenia. Gumley et al. (2006) studied the impact of relapse on patients and also the role of CBT to deal with that and got the results that patients who relapsed showed increased negative beliefs about the illness and reduced self-esteem; that CBT helped in reduction of negative beliefs and for picking up early signs of relapse. Messari and Hallam (2003) studied CBT for psychosis and also got the positive results. A research done by Kannapan (2009) studied two groups one with only medications for people with schizophrenia and the other with medications and psychosocial management and found that patients benefited more with psychosocial interventions with medications. Pilling et al. (2002) researched on psychological interventions in schizophrenia including four types of interventions (family interventions, cognitive behaviour therapy CBT, social skills training and cognitive remediation) and got the findings that CBT produced higher rates of 'important improvement' in mental state and demonstrated positive effects on continuous measures of mental state at follow-up. CBT also seems to be associated with low drop-out rates; also that CBT may be useful for those with treatment resistant symptoms (Psychological Medicine, 2002). Rector, N. & Beck, A. T. (2001) researched on Cognitive Behaviour Therapy for Schizophrenia which showed usefulness of CBT for addressing depression and / or anxiety associated with psychotic symptoms and their impact on the person's life along with its use in dealing with main psychotic symptoms-hallucinations or delusional beliefs Turkington's research on Cognitive-behavioural therapy (CBT) for Schizophrenia also says CBT targets positive symptoms as well as depression with approaches such as social skills training in the management of residual symptoms of chronic schizophrenia. CBT techniques include development of trust, normalizing, coping strategy enhancement, reality testing, and work with dysfunctional affective and behavioural reactions to psychotic symptoms. It has also evidence that psychiatric nurses in the community can use CBT effectively with this patient group under supervision (Turkington D et al, 2006). A research by Zimmermann G.et al, 2005 also depicts that CBT seems to improve the management of positive symptoms of Schizophrenia. William Bradshaw 2000 did a research where he compared effectiveness of long term day treatment program services, dividing schizophrenic patients in two different groups one group who received individual CBT along with day treatment and the other without CBT sessions, and got significant improvement in the group with individual CBT in terms of psychosocial functioning and symptomatology. A research by Mueser K.T, et al. in 2002 also shows effectiveness of CBT techniques with people having severe mental illnesses. This research on Illness Management and Recovery with persons having severe mental illness indicates that psycho education improves peoples' knowledge of mental illness; that behavioural tailoring helps people take medication prescribed to them; that relapse prevention programs reduce symptom relapses and rehospitalisation's; and that coping skills training using cognitive-behavioural techniques reduces the severity and distress of persistent symptoms. Rehabilitation is another important component of psychosocial interventions. Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal condition as possible. The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease (The Free Dictionary by Farlex).The role of patient is important as said by Strauss "schizophrenia patients have an active will". Much of their behaviour is goal directed and reflects an attempt to cope with the illness as best they can (Dunitz Martin 2001). It is essential to view patient as potentially active partner and involve him/her in goal setting and treatment planning; and not to impose treatment plans on them as it increases failure on their part, increases the risk of relapse and makes them uncooperative with treatment providers. It is well established that impairments in information processing is one of the most significant area of dysfunction in schizophrenia, affecting multiple domains including memory, attention, speed of processing, abstract reasoning and sensory motor integration. The rehabilitation plan includes working on these affected domains with rehabilitation strategies: social skills training and cognitive training. Social dysfunction is a defining characteristic of schizophrenia that is semi-independent of other domains of the illness. Social functioning is also predicative of the course and outcome of the illness. Social skills are specific response capabilities necessary for effective performance.

They include verbal response skills (e.g. the ability to start a conversation or to say 'No' when needed), paralinguistic skills (e.g. use of appropriate voice, volume and tone), and nonverbal skills (e.g. appropriate use of gaze, hand gestures and facial expressions) (Dunitz Martin 2001). These skills in social skills training with the help of role plays, homework assignments, are planned to get stable over time and to help patients in their performance of social roles and quality of life. In continuation cognitive rehabilitation helps targeting attention, memory and abstract reasoning deficits. Several findings from past provided evidence that it is possible to achieve enhanced performance on a range of cognitive tasks through practice, instruction, and provision of incentive (Dunitz Martin 2001).Apart from these ways psychosocial rehabilitation includes active therapy, to develop the work habit, training in a new vocation or retraining in a previous skill, vocational guidance, independent job placement, sheltered employment or self-employment, and occupational therapy. Various researches have been done in the area of rehabilitation supporting its usefulness with people having Schizophrenia. One of them is by Krabbendam Lydia and Aleman Andre 2003. They did a research on Cognitive Rehabilitation in Schizophrenia with qualitative analysis of controlled studies and got the results that cognitive rehabilitation can improve task performance in patients with schizophrenia and this effect is seen on other tasks also outside of practiced during training (Krabbendam Lydia and Aleman Andre 2003).Another research on the effects of physical activity on psychological well-being for those with schizophrenia by Holley et al. (2011) suggested physical activity has a beneficial effect on some attributes associated with psychological well-being in schizophrenia. Lehman and Anthony F, 1995 research says recent advances in supported employment vocational training gives better promising results than transitional and sheltered employment approaches; also that it may exert positive influences on medication compliance, symptom reduction and relapse. Liberman et.al 1998 did a comparative study on skills training versus psychosocial occupational therapy for persons with persistent schizophrenia. It suggests that patients receiving skills training showed significantly greater independent living skills during a two year follow up of everyday community functioning. A meta-analytic evaluation of skills training research for individuals with severe mental illness by Dilk, Nichols M., Bond, Gary R. 1996 showed that skills training was found to be moderately to strongly effective in increasing skill acquisition and reducing psychiatric symptoms.
These research findings with available literature suggest that psychosocial treatment is an important adjunt to drug treatment which enhances its efficacy and leads to a more complete recovery and rehabilitation.

SAMPLING:
In this study 25 patients diagnosed with Schizophrenia were randomly selected from rehabilitation centres with age ranges between 18-50 years.

PROCEDURE:
The treatment included individual and group interventions which was completed in five phases
Phase l: Case conceptualization and case formulation, establishment of the therapeutic relationship and alliance.In individual session the therapist was introduced to the patients with gradual establishment of rapport with them.In group therapy all patients were introduced to each other (two groups having 12 members in one and 13 members in the other group) and discussed group therapy rules.
Phase 2: In depth training in social skills to facilitate trust on others and enhance communication skills. This phase was included in both individual and group work. It markedly increased members' comfort in group participation.
Phase 3: Motivation enhancement for formulation of activity schedule chart and to facilitate them for following, recording and interpreting it. This phase helped in mutual identification of their problem areas and planning of strategies to work on them.
Phase 4: In depth training of cognitive techniques – recording and interpreting of automatic thoughts, reattribution and re-rationalization of thoughts and problem solving, as well as understanding the link between Thought and Emotion, and interpretation of the way their Behaviour is affected.

Phase 5: Termination of therapy and feedback. The termination process was started with several repetitions of the main points of intervention, role plays as well as feedback and reflection. After completion of the therapeutic process discussed with patients how they would deal with situations from then on and how they would apply skills they have learnt in everyday life.

Some important techniques of CBT (which were included in the therapeutic phases as well) :

Cognitive techniques such as recognizing and correcting negative automatic thoughts, teaching reattribution techniques, increasing objectivity in perspectives, identifying and testing maladaptive assumptions, and decentring

Behavioural techniques – activity scheduling, homework assignments, graded task assignments, role playing, and diversion techniques

Teaching Problem Solving Skills

Mind fullness (A Short Textbook of Psychiatry by Neeraj Ahuja,2011).

CASE HISTORIES:

Ms A, 30 years old average build female from middle class socio economic status, urban background presented in psychiatry with chief complaints of suspiciousness, muttering to self without any obvious reason, anxiety, sadness of mood, irritability and aggression on occasions, decreased sleep, decreased self-care and social isolation. She was brought by her parents for proper management and hence admitted in IPD. Her diagnosis was Paranoid Schizophrenia. Exploration of history with her parents revealed that the patient's problems started when she went to her college with symptoms of anxiety, lack of concentration in studies, lack of confidence where she would not be able to remember what she read, and with suspiciousness towards her mother saying the mother was hiding her belongings, the mother was jealous of her hence didn't like her to do any good in her life. She would keep on muttering her thoughts in loud voice. Gradually, after completion of MSc, MCA and B.Ed., when she joined a college as guested lecturer her suspiciousness increased she developed paranoia against work people that they want to harm her, take advantage of her, and make fun of her. With this she started having referential ideas against work people and her neighbours. Her behaviour also became odd as she started showing disorganized behaviour while taking lecture in her college. Over the course of her illness, patient was withdrawn to self, gradual decrease in interaction with family members, lack of initiative in doing any work, lack of involvement in any pleasurable activities affecting social, personal and professional life. Her self-care also deteriorated; she would not take bath, change clothes. She would also not come out of her room or go out of her house. There is no family history of any mental illness. Mental status examination revealed decreased psychomotor activity, poor personal hygiene. Patient was conscious of herself and her surroundings; well oriented to time, place and time; her attention was a reusable but concentration was impaired. Her affect was blunt throughout the interview. Her thinking showed delusion of persecution, delusion of reference. Her content of thought revealed hopelessness, worthlessness. PANSS rating at the time of admission revealed positive score of 29 with prominent symptoms of Delusions, Suspiciousness Persecutions and Hostility; the negative score of 27 with prominent symptoms of Blunted affect, Emotional withdrawal, Passive apathetic social withdrawal, and Stereotyped thinking; general psychopathology scale score was 65 with prominent symptoms of anxiety, tension, uncooperativeness, lack of judgement and insight, disturbance of volition, poor impulse control, preoccupation and active social avoidance. Regular individual therapy sessions and group therapy sessions based on CBT approach three months intervention with her resulted reduction of symptoms to a large extent. This is supported by scores on PANSS which are: positive score of 10, negative score of 12, and general psychopathology scale score of 30. The patient was discharged after three months, is continuing her treatment with regular follow ups in OPD. Ms B, 30 years old average build female from middle socio economic status, urban background presented in psychiatry with chief complaints of suspiciousness, self-muttering without any obvious reason, suicidal attempts, binging behaviours in eating, anxiety, irritability and aggression, decreased sleep, decreased self-care and social isolation. The diagnosis was Paranoid Schizophrenia. Her symptoms exploration with parents revealed that the patient was bullied in 11th standard, during the same time her suspiciousness was noticed when she got a haircut after which reported to parents that everyone

was making fun of her and boys would stare at her, she also complained that their neighbours and some nearby working labourers were staring at her. She completed 12th standard, joined B. Pharma studied it for two years, was not able to concentrate, found it difficult so left it and joined B.A English Hons. Currently she is doing her M.A. English. During this whole time self -muttering behaviour, lack of concentration in any task, disorganized behaviour and aggression were observed most of the times. She attempted suicide for four times. Her suspiciousness also increased with time, she once filed a complaint against her father of molesting her. She blamed a couple of her cousins and relatives for misbehaving with her. Over the course of her illness, patient was withdrawn to self, gradual decrease in interaction with family members, lack of initiative in doing any work, lack of involvement in any pleasurable activities affecting social, personal and professional life. Her self-care also deteriorated; she would not take bath, change clothes. She would also not come out of her room or go out of her house. She also developed phobia with exams. Family history of mental illness is there- patient's grandmother (father's mother) was suffering from depression. Patient's aunt's daughter (massi's daughter) has psychiatric illness. During Mental status examination patient was conscious of herself and her surroundings; well oriented to time, place and time; her attention was aroused but concentration was impaired. Her affect was blunt throughout the interview. Her thinking showed delusion of persecution, delusion of reference. Her content of thought revealed hopelessness and hostility. PANSS rating at admission showed positive score of 31 with prominent symptoms of delusions, hallucinatory behaviour, suspiciousness and hostility. Negative score was 27 with prominence of emotional withdrawal, poor rapport, Apathetic social withdrawal and stereotyped thinking. General psychopathology score was 54 with anxiety, tension, uncooperativeness, poor attention, lack of judgement and insight, poor impulse control and active social avoidance. After three months of individual and group interventions based on CBT approach PANSS rating was re done getting positive score of 10, negative score of 9 and general psychopathology scale score of 17. The patient is in regular follow up. Mrs C, 45 years old female with average build comes from a middle class family urban background married but separated presented with complaints of suspiciousness, hallucinations, disturbed sleep and appetite, wandering behaviour, aggression and impulsive behaviours, fearfulness, anxiety, loosening of associations, poor self-care and catatonic postures. Her diagnosis was Undifferentiated Schizophrenia. Mrs .C with educational background of M.A in arts did work in a polytechnic as a hobby class instructor. She has 16 years duration of illness with episodic course with inter-episodic partial remission. Her first episode was followed by her mother's death with clinical features of catatonic posturing, withdrawn behaviour, complicated grief, and psychotic symptoms of hallucinations, suspiciousness. Treatment was given with recovery within two to three months. Second episode was after her delivery, post-partum phase in form of suspiciousness, withdrawn behaviour, irrelevant talk. There was partial recovery with medication, patient got functional but communication, interpersonal interaction continued to be problematic. The patient separated from her husband staying with her sister and brother-in-law. In past three years they have observed persistent symptoms with episodic exacerbation. In the past three months symptoms exacerbated with disorganized behaviour, irrelevant talk, irritability and poor self-care. There is no family history of any mental illness. In mental status examination the patient was conscious, cooperative, and communicative with spontaneous communication revealing loosening of associations. Attention was aroused but concentration was impaired, orientation (place, time and person) was impaired, recent and immediate memory was impaired but remote memory was intact. Her affect was blunt. Thinking revealed suspiciousness and unusual thought content. Perception was impaired with visual and auditory hallucinations. PANSS rating at the time of admission showed positive score of 35 with prominent symptoms of delusions, conceptual disorganization, hallucinatory behaviour, suspiciousness and hostility. The negative score was 28 with symptoms prominence on blunted affect, emotional withdrawal, passive apathetic social withdrawal, difficulty in abstract thinking. The score on general psychopathology scale was 70 with symptoms of somatic concern, anxiety, tension, unusual thought content, disorientation, poor attention, lack of judgement and insight, disturbance of volition, poor impulse control, preoccupation and active social avoidance. Three months intervention using individual and group therapy work based on CBT the assessment was re-done in which PANSS score on positive scale was 10, negative scale core was 15 and

on general psychopathology scale the score was 30. The patient is in regular treatment. Mr D, 34 years old unmarried with average body build comes from middle socio economic status urban background presented in psychiatry with complaints of withdrawn behaviour, irritability, suspiciousness in initial course of illness, fearfulness, poor self-care, aggression and violent behaviour which has decreased in past 3-4 years, minimum to no communication, not allow anyone to enter his room, keeping his room disorganized, filthy and does not let it be cleaned, not doing any work. The diagnosis is Chronic Schizophrenia. He has 12 years duration of illness with continuous course. The patient was alright 12 years back when during first year of his graduation course had faced ragging by the college mates. The details are not known but the patient thereafter never pursued any studies. After that his symptoms continued with gradual increase in social withdrawal, poor self-care, disorganisation, and decrease in communication.

No family history of any mental illness.

During mental status examination the patient was anxious, not very communicative, disturbed state. His hair was in poor condition, was wearing inappropriate clothes. The eye contact was established but not maintained. His attention was poor. Affect was restricted. Orientation was impaired with impaired judgement. PANSS rating was done in which the positive score was 32 with prominent symptoms of delusions, conceptual disorganization, hallucinatory behaviour, suspiciousness. The score on negative scale was 42 with symptoms of blunted affect, emotional withdrawal, poor rapport, apathetic social withdrawal, difficulty in abstract thinking, lack of spontaneity and flow of conversation, and stereotyped thinking. The score on general psychopathology scale was 76 with symptoms of anxiety, motor retardation, uncooperativeness, disorientation, poor attention, lack of judgement and insight, disturbance of volition, poor impulse control, preoccupation and active social avoidance. With interventions based on CBT the patient showed a lot of improvement which was again assessed with PANSS score. The score on positive scale was 17, the negative scale score was 17 and on general psychopathology scale the score was 31. The patient got discharged with no regular follow up late on. Mr E, 48 years old average build comes from middle economic statues urban background Muslim religion came in psychiatry with complaints of withdrawn behaviour, suspiciousness towards neighbours, aggression and violence, self-muttering, increased religiosity, disorganized behaviour, poor self-care. The patient has 30 years duration of illness with continuous course with exacerbation of symptoms in between. His diagnosis is Chronic Paranoid Schizophrenia. The patient was 17 years old when his illness started. 1984 riots were going where he started keeping fasts saying it would help everyone. He completed his civil engineering in 1996, worked for a year but then dropped, got married when he was 30, the marriage continued for 5-6 years after which his wife got separated by her choice. The illness progressed with increase in suspiciousness, hallucinations saying he is talking to 'Gins' or talking to his wife and kids, increased religiosity, with disorganized behaviour where he would throw every household things out of his house, would stay in his room, would not interact with people, and increased aggression.

There is no family history of any mental illness.

In mental status examination the patient was conscious, cooperative, and communicative. The eye contact was established and maintained. His attention was aroused but concentration seemed impaired. Orientation and memory was intact but judgement was poor. Thinking revealed suspiciousness, grandiosity, with high religiosity and unusual thought content. His perception included visual and auditory hallucinations. PANSS scores included positive score of 39 with prominent symptoms of delusions, conceptual disorganization, hallucinatory behaviour, excitement, grandiosity, and suspiciousness. The score on negative scale was 36 with symptoms of blunted affect, emotional withdrawal, poor rapport, apathetic social withdrawal and stereotyped thinking. General psychopathology scale score was 65.After three months intervention PANSS score was obtained again with the positive score of 13, the negative scale score of 12 and the score of general psychopathology scale was 25. The patient is in regular treatment.

CONCLUSION:

Schizophrenia is a disorder that lasts for at least six months and includes at least one month of active phase symptoms (i.e. two or more of the following: delusions, Hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, negative symptoms). The characteristic symptoms of schizophrenia may be conceptualized as falling into two broad categories: positive and negative.

The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a dimension or loss of normal functions. The positive symptoms include distortions in thought content (delusions), perceptions (hallucinations), language and thought process (disorganized speech), and self-monitoring of behaviour (grossly disorganized or catatonic behaviour). The negative symptoms are affective flattening, alogia (poverty of thoughts/ speech), anhedonia (inability to experience pleasure), associability (lack of desire to form relationships) and a volition (lack of motivation) (Kaplan and Sadock, 2003). The treatment of schizophrenia includes pharmacological treatment (medication), psychosocial treatment and rehabilitation. Psychosocial treatment is an important component of comprehensive management of schizophrenia which includes Psycho education, group psychotherapy, family therapy, individual psychotherapy, and psychosocial rehabilitation. Cognitive Behaviour Therapy CBT plays a major role in providing psychosocial treatment. Its effectiveness has been seen in the present study with variations in PANSS scores of 25 Schizophrenic Patients after given therapeutic interventions based on CBT approach. Several researches done in the past also supports the results of the present study. Gumley et al. (2006) did research on CBT showed that CBT helped in reduction of negative beliefs about the illness and for picking up early signs of relapse. Messari and Hallam (2003) studied CBT for psychosis and also got the positive results. Rector, N. & Beck, A. T.

(2001) addressed depression and / or anxiety associated with psychotic symptoms and showed usefulness of CBT for addressing it along with its use in dealing with main symptoms-hallucinations or delusional beliefs. Another research by Zimmermann G, Favrod J, Trieu V.H, Pomini V, in 2005 also depicts that CBT seems to improve the management of positive symptoms of Schizophrenia.A research on effectiveness of CBT techniques with people having severe mental illnesses indicates that psycho education improves peoples' knowledge of mental illness; that behavioural tailoring helps people take medication prescribed to them; that relapse prevention programs reduce symptom relapses and rehospitalisation; and that coping skills training using cognitive-behavioural techniques reduces the severity and distress of persistent symptoms (Mueser K.T et al. 2002).Various comparative studies have also been done which showed better results with psychosocial interventions based on CBT. Out of them one is done by Kannapan (2009) where two groups one with only medications for people with schizophrenia and the other with medications and psychosocial management were taken into consideration and found that patients benefited more with psychosocial interventions with medications. The other similar research is by William Bradshaw 2000 where effectiveness of long term day treatment program services was studied, dividing schizophrenic patients in two different groups one group receiving individual CBT along with day treatment and the other without CBT sessions. The results showed significant improvement in the group with individual CBT in terms of psychosocial functioning and symptomatology.

RECOMMENDATIONS:

Psychosocial interventions based on Cognitive Behaviour Therapy play a very important role in rehabilitation of patients with Schizophrenia in terms of improving their social, occupational and personal functioning along with their symptoms management. Hence it is reinforcing the need of individual and group CBT work with Schizophrenic patients in rehabilitation settings.

REFERENCES:

1. Dilk, Nichols M., Bond, Gary R. 1996, Meta Analytic Evaluation of Skills Training Research for Individuals with Severe Mental Illness, Journal of Consulting and Clinical Psychology, Vol 64(6), pp. 1337-1346, available at : http://dx.doi.org/10.1037/0022-006X.64.6.1337, accessed on : 6th April, 2015.
2. Dunitz Martin 2001, Comprehensive Care of Schizophrenia: A Textbook of Clinical Management; Edited by Lieberman J.A. and Murray R.M. in India by Jaypee Brothers Medical Publishers Pvt. Ltd.
3. Gumley, A., Karatzias, A., Power, K., Reilly, J., McNay, L., Grady, M.O; (2006). Early Intervention for Relapse in Schizophrenia: Impact of Cognitive Behaviour Therapy on Negative Beliefs about Psychosis and Self Esteem; British Journal of Clinical Psychology, 45,247-260.
4. Holley, J., Crone, D., Tyson, P., Lovell, G.; (2011). The Effects of Physical Activity on Psychological Well- being for those with Schizophrenia; British Journal of Clinical Psychology, 50, 67-83.
5. Kannappan, R., (2009). Intervention for Reducing the Distress of Schizophrenic Patients; Journal of the Indian Academy of Applied Psychology; July, 35, 257-263.
6. Kaplan, Sadock, B.J., Sadock, A.J.; (2003) Synopsis of Psychiatry Behavioral Sciences/ Clinical Psychiatry; Lippincott Williams and Wilkins.
7. Krabbendam Lydia and Aleman Andre 2003,Cognitive Rehabilitation in Schizophrenia A Qualitative Analysis of Controlled Studies, Psychopharmocology169:376-382, copyright Springer Verlag, DOI 10.1007/s00213-002-1326-5, available at: http://link.springer.com/article/10.1007/s00213-002-1326-5#page-2, accessed on: 6th April, 2105).
8. Lehman and Anthony F, 1995, Vocational Rehabilitation in Schizophrenia, Schizophrenia Bulletin, vol 21(4), 1995, 645-656, APA PsycNET, available at: http://psycnet.apa.org/journals/szb/21/4/645/, accessed on : 6th April, 2015)
9. Liberman R.P. et.al. 1998, Skills Training versus Psychosocial Occupational Therapy for Persons with Persistent Schizophrenia, The American Journal of Psychiatry, volume 155 issue 8, pp. 1087-1091, available at: http://dx.doi.org/10.1176/ajp.155.8.1087 , accessed on : 6th April, 2015).
10. Messari, S., Hallam, R.; (2003). CBT for Psychosis: a Qualitative Analysis of Clients' Experiences; British Journal of Clinical Psychology, 42,171-188.
11. Million. T, Blankey P. H. and Davis R.D. 1999; Oxford Textbook of Psychopathology; New York Oxford; Oxford University Press.
12. Mueser K.T, Corrigan P.W, Hilton D.W, Tanzman B, Gingerich S, Essock S.M, Tarrier N, Morey B, Vogel-Scibilia S, Herz M.I, 2002, Illness Management and Recovery: A Review of the Research, copyright @ American Psychiatric Association, Psychiatric Services, Vol.53, Issue.10, October 2002, pp.1272-1284, available at http://dx.doi.org/10.1176/appi.ps.53.10.1272, accessed on 27th March 2015).
13. NeerajAhuja 2011; A Short Textbook of Psychiatry; Seventh Edition; Jaypee Brothers Medical Publishers Pvt Ltd.
14. Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G., Morgan, C.; (2002). Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy; Psychological Medicine, 32, 763-782.
15. Psychological Medicine, 2002, 32, 763–782. " 2002 Cambridge University Press DOI: 10.1017}S0033291702005895 Printed in the United Kingdom, available at http://discovery.ucl.ac.uk/2119/1/BP.pdf., accessed on 27th March 2015.
16. Rector, N. & Beck, A. T. 2001, Cognitive Behavioural Therapy for Schizophrenia, Society of Clinical Psychology American Psychological Association, available at http://www.div12.org/psychological-treatments/treatments/cognitive-behavioral-therapy-cbt-for-schizophrenia/ accessed on 27th March 2015.
17. The Free Dictionary by Farlex. Copyright © 2003-2015 Farlex, Inc. Available athttp://medical-dictionary.thefreedictionary.com/Rehabilitation, Accessed on: 23 March 2015.
18. Turkington D, Dudley R, Warman D. M, Beck A .T, 2006, Cognitive-behavioral therapy (CBT) for Schizophrenia: A Review, copyright @ American Psychiatric Publication, Volume 4 Issue 2, April 2006, pp. 223-233, available at http://dx.doi.org/10.1176/foc.4.2.223 , accessed on 27th March 2015.
19. Wikipedia, The Free Encyclopedia, last updated : 25 march, 2015, Cognitive Behaviour Therapy, available at http://en.wikipedia.org/wiki/Cognitive_behavioral_therapy#Description, accessed on 27th March, 2015.
20. William Bradshaw 2000, Integrating Cognitive Behavioural Psychotherapy for Persons with Schizophrenia into a Psychiatric Rehabilitation Program: Results of a Three Year Trial, Community Mental Health Journal, vol.36, No.5, October 2000, available at http://link.springer.com/article/10.1023/A:1001911730268#page-2, accessed on 27th March, 2015.
21. Zimmermann G, Favrod J, Trieu V.H, Pomini V, 2005, The Effect of Cognitive Behavioural Treatment on the Positive Symptoms of Schizophrenia Spectrum Disorders: A Meta-Analysis, Schizophrenia Research the official journal of the Schizophrenia International Research Society, September 1, 2005 volume 77, issue l, pages 1-9, available at http://dx.doi.org/10.1016/j.schres.2005.02.018, accessed on 27th March 2015.